DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/20/2011 FORM APPROVED OMB NO. 0938-0391

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
		09G087	B. WING				
NAME OF S	CONSTRUCTO	093067				10/2011	
- •	PROVIDER OR SUPPLIER AL FOUNDATION		\$	TREET ADDRESS, CITY, STATE, ZIP CO 722 "L" STREET, NE WASHINGTON, DC 20002	3 OOE		
(X4) IO PREFIX	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CO	PRRECTION N SHOULD BE	(X5) COMPLETIC	
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIATE	DATE	
W 000	INITIAL COMMENT	rs	W 00	O Symbral's governing body will en	enem that all		
				jrequired policies are implemented	i to safeguard	i	
,	A recertification sur	vey was conducted from June;		and provide habilitation to the inc	lividuals we	6/20/11 an	
	8, 2011 through Jun	e 10, 2011. A sample of two		serve.		ongoing	
	chents was selected	from a population of two		In addition, these policies will be	aligned to the	:	
		cognitive and intellectual rivey was conducted utilizing		present Health & Wellness Stands other best practices guide.	ırds, as well as	İ	
	the fundamental sur			i pest biacuces guide.		!	
		, , , , , , , , , , , , , , , , , , ,		Symbrai's governing body and QA		İ	
	The findings of the s	survey were based on		continue to monitor to ensure com	pliance.	•	
	observations and int	erviews with one client and		ļ			
		d at two day programs, as					
		lient and administrative		:			
\A/ 4EE		cident/investigation reports.	161 45				
	483.420(d)(4) STAF CLIENTS	F IREAIMEN! OF	W 156				
	The results of all inve	estigations must be reported		Symbral IMC has updated the inv	estigative report	!	
		or designated representative		, form to include a review section fo	r Symbral's	6/20/11 and	
	within five working d	accordance with State law		Administrator's (CEO) signature of her knowledge of all incident in	as an affirmation	ongoing	
	ARTHUR HAD MOLKERIS OF	aya of the incident.		findings within five working days.	resti ga tive	!	
,	This STANDARD is	not met as evidenced by:		Symbral's governing body & QA	leam witi	į	
	Based on Interview	and record review, the facility		continue to monitor to ensure com	pilance.	,	
1	failed to report the re	sults of all investigations of		1 a wad			
•	verbal abuse to the a	dministrator within five		Received,			
		ncident, for one two sampled		10/24/11			
•	clients. (Client #1)]		Department of Hea	lth		
	The finding includes:			: Health Regulation & Licensing A	dministration		
	THE INTERIOR	į		Intermediate Care Facilitie	s Division		
(On June 9, 2011, beg	jinning at 1:25 p.m., review		860 North Capitol St.	N'E'		
× C	of incident reports an	d corresponding		Washington, D.C. 20	002		
		d that on August 26, 2010,		•	i		
		abused by his 1:1 staff					
	vhile at the day progr				,		
		ember 22, 2010, Client #1 ed by facility staff that		,			
V	vas verbany uneaten	EU DY LOUINTY STORES (LUGIC					

To: 2024429430

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days ollowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 lays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 06/20/2011 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A. BUILDING B. WING 09G087 06/10/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 722 "L" STREET, NE SYMBRAL FOUNDATION WASHINGTON, DC 20002 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE MPLETION DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY W 156 Continued From page 1 W 156 Continued from page 1. supported him in his home and at the day program. Both investigations were completed and signed off on by the facility's Incident Management Coordinator (IMC). However, there was no evidence that administrators had reviewed and signed off on the Investigations within five working days. Interview with the Qualified Intellectual Disability Professional (QIDP) on June 9, 2011, at approximately 1:50 p.m., acknowledged that the facility's administrators had not reviewed and signed the two aforementioned investigative reports within five working days. W 159 483,430(a) QUALIFIED MENTAL W 159 RETARDATION PROFESSIONAL Each client's active treatment program must be (1,2,3) QIDP, House Manager (s) and all staff working with individuals # 1 & 2 received reintegrated, coordinated and monitored by a 6/24/11 and qualified mental retardation professional, ongoing training on 6/24/11 on implementation for BSP, adherence to Meal Time Protocols and Portion Controis. This STANDARD is not met as evidenced by: Symbral's governing body, QA Team, QIDP, and Based on observation, interview, and record House Manager will continue to monitor to ensure compliance. review, the facility failed to ensure that the Qualified Intellectual Disabilities Professional (QIDP) monitored services, for two of two sampled clients. (Clients #1 and #2) The finding includes: 1. Cross refer W193. The facility's QIDP failed to ensure 1:1 staff demonstrated competency in implementing Client #1's behavior support plan.

Cross refer to W249. The facility's QIDP failed to ensure Client #1 received continuous active treatment in accordance with the

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		09G087	8. WI	NG_		96	/10/2011
1	PROVIDER OR SUPPLIER			7	REET ADDRESS, CITY, STATE, ZIP CODE 722 "L" STREET, NE WASHINGTON, DC 20002		10/2011
(X4) IO PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	3. Cross refer to W ensure that Clients a balanced, nutritious their dietary orders. 483.430(e)(3) STAF Staff must be able to techniques necessa	ge 2 m (IDT) recommendations. 460. The QIDP failed to #1 and #2 received well meals in accordance with F TRAINING PROGRAM of demonstrate the skills and ry to administer interventions propriate behavior of clients.	w 1	93	Continued from page 2,	V159.	6/24/11 and ongoing
;	Based on observation review, the facility state competency in the in Behavior Support Plasampled clients. (Clients finding includes: Cross refer to W249, that 1:1 staff demons implementing Clients (BSP). 483.440(d)(1) PROGAS soon as the interd formulated a client's if each client must receive treatment program conterventions and send and frequency to supplements in the supplements of the su	The facility failed to ensure strated competency in #1's Behavior Support Plan RAM IMPLEMENTATION lisciplinary team has individual program plan, live a continuous active	W 24	C	Crossed referenced and adopted with W W193.	159 and	6/24/11 and ongoing

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) N A BU		IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		09G087	8. W	NG_		06/1	0/2011
	PROVIDER OR SUPPLIER			7	REET ADDRESS, CITY, STATE, ZIP CODE 122 "L" STREET, NE WASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREF TAG	X	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	WLO BE	(X5) COMPLETION DATE
W 249	Continued From pa	ge 3	w	249			<u>.</u>
	Based on observat review, the facility s Behavior Support P	s not met as evidenced by: ion, interview, and record taff failed to ensure a client's lan (BSP) was implemented of two sampled clients.			Continued from page 3.		
	The finding includes	i.					
		ensure that Client #1's 1:1 use proximity in accordance dence below:					
	observed to walk over my hand and sat do remained in the kitcl p.m. the 1:1 staff respreparing dinner who dining table with the Client #1 answered stocated in the living sphone to his 1:1 staff Client #1 received vewhen standing to clopuring this time, the kitchen. On June 9, was left alone in the one minute while his	4:10 p.m., Client #1 was er to the dining table to shake who white his 1:1 staff then preparing dinner. At 4:15 mained in the kitchen ie Client #1 remained at the surveyor. At 4:27 p.m., the cordiess telephone com area and brought the fin the kitchen. At 5:35 p.m., erbal prompts to back up se to the female staff. 1:1 staff remained in the 2011, at 4:48 p.m., Client #1 living room for approximately 1:1 staff walked upstairs.					
: : : :	approximately 4:42 p received 1:1 staffing his maladaptive beha nappropriate touchin personal space and s	staff on June 8, 2011, at .m., revealed that Client #1 24 hours a day to manage inviors and safety. (i.e. g, invading another person's sexually propositioning ing, yelling, screaming, and		7746			

PRINTED: 06/20/2011 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 09G087 06/10/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 722 "L" STREET, NE SYMBRAL FOUNDATION WASHINGTON, DC 20002 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X4) ID ın (X5) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) W 249 Continued From page 4 W 249 making threats, refusing to comply with staff Continued from page 4. requests, verbal aggression, and physical aggression). Further interview with Client #1's 1:1 staff acknowledged that he did not remain in close proximity at all times as observed on June 8, 2011. Review of Client #1's BSP dated February 28. 2011, on June 10, 2011, at 9:43 a.m., confirmed the 1:1 staff's interview of the aforementioned maladaptive behaviors. Further review of Client #1's BSP revealed the 1:1 staff must remain within close proximity at all times (i.e., home, community, day, and while being transported). The BSP also added that Client #1's 1:1 staffing was in place for safety precautions relative to sexually propositioning others. At the time of the survey, there was no evidence that Client #1's 1:1 staff implemented his BSP as recommended. W 331 483.460(c) NURSING SERVICES W 331 LPN Case Manager re-inserviced medication nurse 6/20/11 and The facility must provide clients with nursing on Health & Wellness Practices relating to going services in accordance with their needs. Prevention and Control of infection. Symbral's governing body, OA Team, DON, LPN Case Manager, QIDP and House Manager will This STANDARD is not met as evidenced by: provide oversight. Based on observation, interview, and record review, the facility failed to ensure nursing services were provided in accordance with each clients needs, for one of two sampled clients. (Client #1) The finding includes: Cross Refer to W455. The facility's nursing staff failed to ensure proper infection control

To: 2024429430

DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES**

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) M A. BUI		IPLE CONSTRUCTION	(X3) DATE S	
	·	09G087	8. Wh	4G _		06/-	10/2011
	PROVIDER OR SUPPLIER			7	REET ADDRESS, CITY, STATE, ZIP CODE 122 "L" STREET, NE NASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	Client #1's prescribe 483.470(i)(1) EVAC The facility must hol quarterly for each st This STANDARD is Based on interview failed to hold evacua shifts, for two of two (Clients #1 and #2) The finding includes: The facility failed to cleast four times (4) a evidenced below: On June 9, 2011, at: Qualified Intellectual (QIDP) revealed that shifts (8:00 AM - 4:00 and 11:00 PM - 8:00 Further interview rew designated shifts (9:0 PM - 9:00 AM) for the (Saturday/Sunday). Review of the facility.	ed prior to administering ed eye drops. UATION DRILLS Id evacuation drills at least nift of personnel. In not met as evidenced by: and record review, the facility ation drills quarterly on all clients residing in the facility. Conduct simulated fire drills at year for each shift, as 2:13 p.m., interview with the Disabilities Professional there were three designated DPM; 3:00 PM -11:00 PM AM) Monday thru Friday, ealed that there were two 20 AM - 9:00 PM and 9:00	Wa	140		cross kdays) and back door and li Staff were	6/24/11 and ongoing
W 441	that no drills were hel morning shift from Oc December 2010. Thi	Id during the weekday ctober 2010 through s was acknowledged by the a House Manager on June m.	W 44	.1			

To:2024429430

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTE	ERS FOR MEDICARE	& MEDICAID SERVICES				OMB NO	<u>). 0938-039</u> 1
	nt of deficiencies of correction	(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:	(X2) M		PIPLE CONSTRUCTION	(X3) DATE (
		09G087	B. WII	NG.		06/	10/2011
NAME OF	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE 722 "L" STREET, NE		
SYMBR	AL FOUNDATION				WASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDERS PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 441	Continued From pa	ge 6	W 4	441			:
	varied conditions.	ld evacuation drills under			QIDP redo fire drill calendar to incorposition in the complementation of Evacuation Drifts are specified shift (8:00 am - 4:00 pm weeks utilization of all exit areas to include basement door.	oss lays) and	6/2-4/11 and ongoing
	Based on the interview records, the facility is	s not met as evidenced by: riew and review of the fire drill failed to conduct fire drills ons, for two of two clients			In addition, House Manager (s) and ali inserviced as explained done.		!
		y. (Clients #1 and #2)			Symbrai's governing body, QA Team, Q House Manager (s) will monitor to ensu compliance.		
	The finding includes	:					
	Professional (QIDP) p.m., revealed that the methods of egress (basement door). Represented that most of conducted utilizing the review of the fire drill back door and baser used since June 201 through additional in same day at approximation of evidence on substantiate that all 483.470(I)(1) INFECT	ne front door exit. Further I records revealed that the ment door exit had not been 0. This was acknowledged terview with the QIDP on the mately 12:05 p.m. There file at the time of survey to exits were used.	W 45	55	Crossed referenced and adopted wilb WJ	131.	6/20/11 and
	and communicable d	iseases.					ongoing
		not met as evidenced by: in and interview, the facility ctive program for the					
· · · · · · · · · · · · · · · · · · ·							

	· - · · · · · · · · · · · · · · · · · ·	AND HUMAN SERVICES & MEDICAID SERVICES			FOR	D: 06/20/2011 M APPROVED O: 0938-0391
	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A BUILD	LTIPLE CONSTRUCTION NNG	(X3) DATE	
		09G087	B. WING		06	10/2011
	PROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE 722 "L" STREET, NE WASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETION DATE
W 455	Continued From page	-	W 45	5		
	prevention and cont communicable diser- clients. (Client #1)	rol of infection and asses for one of two sampled		Continued from page 7.		
	The finding includes					
	infection control pro-	staff failed to ensure proper cedures were used prior to #1's prescribed eye drops.		i		
	Licensed Practical Nash her hands with administering medic provided minimal as punched his medical	approximately 6:44 p.m., the lurse (LPN) was observed to a soap and water prior to ations. At 6:45 p.m., the LPN sistance to Client #1 as he tions into the medication cup				
	The LPN placed the medication cabinet. the LPN was then of	medications independently medications back into the At approximately 6:50 p.m., eserved to administer one eye Client #1 with her bare		: !		,
	hands. She was not	observed to wash and/or efore administering the eye				
	2011, at approximate the medication nurse	N coordinator on June 10, bly 12:00 p.m., revealed that should have washed her s on prior to administering				
W 460	483.480(a)(1) FOOD SERVICES		W 460	Food & Nutrition Consultant re-trained working with individuals #1 and #2 on ".	Adherence	6/24/11 and ongoing
	Each client must recovered diet incorporation	cluding modified and		to Meal Time Protocol (Modified diets): Control as specified".	and Portion	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS SOR MEDICARE & MEDICAID SERVICES

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CENIE	NO PUR MEDICARE	A MEDICAID SERVICES				OMB NO). 0938-0391
	STATEMENT OF DEFICIENCIES (X1) PROVIDERSUPPLIERICLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) A. BU		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ļ		09G087	B. Wi	NG_		06/-	10/2011
}	PROMDER OR SUPPLIER AL FOUNDATION			7	REET ADDRESS, CITY, STATE, ZIP CODE 122 "L" STREET, NE NASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	This STANDARD is Based on observat review, the facility fareceived their preso ordered by the physicilents. (Clients #1 a The finding includes The facility falled to received a well-bala their Primary Care Fitheir nutritional need on June 8, 2011, at was observed sitting to music and watchis appeared to look a list Staff #1 was observed of snap peas and wholates using a silver meal. The staff also bread with marganial Review of the June 2 (PO's) on June 9, 20 p.m. revealed that Cl 1800 calorie diet and 1500 calorie diet.	s not met as evidenced by: ion, interview and record ailed to ensure clients ribed modified diets as ician, for two of two sampled and #2)	W 4		In addition staff working at the time of received disciplinary action to this regal Symbral's governing body, QA Team, N DON, LPN Case Manager, QIDP and F Manager will continue to monitor to encompliance.	ird. Nutritionist, Touse	6/24/11 and ongoing
\ ;	When asked how did #2 received the appro	he know that Client #1 and opriate amount of food, Staff "I know the amount, I've		1 1		! ! !	

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Health Regulation & Licensing Administration

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU HFD03-0005	ERICLIA MBER:	(X2) MUL A. BUILD B. WING		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER	111 200-0000	STREET AD	DRESS CITY	, STATE, ZIP CODE	06/1	0/2011
SYMBRAL FOUNDATION		722 "L" S	TREET, N			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(XS) COMPLETE DATE
1 000 INITIAL COMMENTS			1000	Symbral's governing body received deficited, we will ensure that corrective mea implemented to prevent reoccurrences.	clencies as sures are	6/20/11 and ongoing
1042 3502.2(b) MEAL SERVICE / DINING AREAS Modified diets shall be as follows: (b) Planned, prepared, and served by individuals who have received instruction from a dietitian; and			1 042	Food & Nutrition Consultant re-trained working with individuals #1 and #2 on "/ to Meal Time Protocol (Modified dlets) a Control as specified". In addition staff working at the time of streeelved disciplinary action to this regar	Adherence and Portion	6/24/11 and ongoing
This Statute is not met as evidenced by: Based on observation, interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure residents received their prescribed modified diets as ordered by the physician, for two of two sampled residents. (Residents #1 and #2)				Symbral's governing body, QA Team, Nu DON, LPN Case Manager, QIDP and Ho Manager will continue to monitor to ensi compliance.	atritionist,	
The finding includes: The GHPID failed to ensure that Residents #1 and #2 received a well-balanced diet as prescribed by their Primary Care Physician (PCP) to ensure their nutritional needs, as evidenced below:			ĺ			
On June 8, 2011, at 4 #2 was observed sitti listening to music and residents appeared to 5:45 p.m., Staff #1 will large scoops of snap residents' plates using dinner meal. The state wheat bread with main plates.	ing on the sofa chair distribution watching television to look a little overweas observed to place peas and white noog a silver spatula duff also placed two pingarine onto the clier	s. The ight. At e two onto the ring the eces of its				
Review of the June 201 (PO's) on June 9, 201 with Regulation & Licensing Administra	11, at 3:35 p.m., and				 	
In Leading of S DONIES OF WILLIAM	"T'~/ 1. 1	,		TITLE (CC)	Loui	S) DATE

Health Regulation & Licensing Admiristration

ABORATORY DIRECTOR'S DIVERSION PLIES REPRESENTATIVE'S SIGNATURE

TITLE (1 80

(X8) DATE 623/2011 Health Regulation & Licensing Administration

#536 P.016/031

	TATEMENT OF DEFICIENCIES (X1) PROVIDERSUPPLIER/CLIA IDENTIFICATION NUMBER		(X2) MU A. BUILI B. WING		(X3) DATE SURVEY COMPLETED		
		HFD03-0005	,			08/10/2011	
NAME OF	PROVIDER OR SUPPLIER				Y, STATE, ZIP CODE		
SYMBRA	AL FOUNDATION		722 "L" S' WASHING				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL :	ID PREFIX TAG	PROMDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
1 042	Continued From page	ge 1		1042			
	p.m. revealed that R 1800 calorie diet and a 1500 calorie diet.	- tesident#1 was pres			Continued from page 1.		
	Interview with Staff at p.m., confirmed that use measuring cups food. When asked ! Resident #1 and #2 amount of food, Staf know the amount, I'v now."	on June 8, 2011, he to measure the resinow did he know that received the approper #1 replied by sayin	e did not idents t niate g. "I				
	On June 10, 2011, a review of the dinner revealed that resider calorie diet was to recup of snap peas, on teaspoon of margarir dinner menu revealed 1500 calorie diet was rice, 1/2 snap peas, a	menu for June 8, 20 it's prescribed an 18 ceive 1 cup of white e slice of wheat brei e. Further review o d that resident's pre- to receive a 1/2 cup	11, 00 rice, 1 ad, and a f the scribed a of white				
1	Note: It should be no desirable body weigh His current weight is is 150 lbs - 192 lbs. I	t (DBW) is 128 lbs - 190 lbs. Resident#	168 lbs. 2's DBW				:
1090 3	3504.1 HOUSEKEEP	PING		090		;	-
1 8 8	The interior and extermaintained in a safe, and sanitary manner accumulations of dirt, odors.	clean, orderly, attractand be free of	ctive,		Work request order form was completed Manager on same day 6/10/11 and submi Maintenance Department.		6/20/11 and ongoing
E +	This Statute is not me Based on observation Home for Persons wit	and interview, the C h Intellectual Disabil				; ;	

Health Regulation & Licensing Administration

#536 P.017/031

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		A BUILT		(X3) DATE SURVEY COMPLETED			
		HFD03-0005		B. WING		06	/10/2011		
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CIT	SS, CITY, STATE, ZIP CODE				
SYMBRA	AL FOUNDATION			STREET, NE NGTON, DC 20002					
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETE DATE		
1 090	Continued From page	ge 2		I 090		~			
	(GHPID) maintained the interior and exterior of the facility in a safe, clean, orderly, attractive, and sanitary manner, for two of two sampled residents. (Residents #1 and #2) The findings include:			Itemized job descriptions 1-3 were co 6/15/11. QA Tenm, QIDP, House Manager an Maintenance Engineer will continue to prevent reoccurrence.	d	6/20/11 and ongoing			
	Observation and interview with the facility House Manager (HM) and Qualified Intellectual Disabilities Professional (QIDP) on June 10, 2011, beginning at 1:47 p.m., revealed the following:								
	Interior						!		
	The bathroom window located on the first level was observed to be inoperable. The bathroom window would not to open.								
	Exterior								
•	The lint trap outsign with heavy build up or	de the facility was ot f dirt and rubbish.	served						
1	 The fence located facility was observed bottom. 	*							
á	The QIDP and the HI above-cited deficience environmental walk-ti	ies at the conclusion					:		
1 135 3	3505.5 FIRE SAFET	1		i 135			\$:		
Ċ	Each GHMRP shall conder to test the effectour (4) times a year f	tiveness of the plan			Sec page 4.				
	This Statute is not me	<u> </u>							

#536 P.018/031

Health I	Regulation & Licensin	ng Administration					
	IT OF DEFICENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		A BUILD	ING	3) DATE S C OM PL	
		HFD03-0005		B. WING		06/1	0/2011
NAME OF F	ROMDER OR SUPPLIER		STREET AD	DRESS, CITY	, STATE, ZIP CODE		
SYMBRA	AL FOUNDATION			TREET, NETON, DC			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(XS) COMPLETE DATE
l 135	Continued From page	ge 3		I 135			
	home for intellectua hold evacuation drill two of two residents (Residents #1 and #	•) failed to fts, for		Fire Drili Caiendar now reflects specified evacuation drills for cited shift. House Man and staff were re-trained on updated fire dr caiendar. Symbral's governing body, QA Team, QIDI House Manager (s) will continue to monitor	riii Pand	6/24/11 and engoing
;	The finding includes The GHPID failed to at least four times (4 evidenced below: On June 9, 2011, at qualified intellectual (QIDP) revealed that shifts (8:00 AM - 4:00 and 11:00 PM - 8:00 Further interview revidesignated shifts (9: PM - 9:00 AM) for the (Saturday/Sunday). Review of the GHPID June 13, 2011, begin that no drills were he moming shift from O December 2010. The GHPID's QIDP and the 10, 2011, at 11:42 a.	conduct simulated (a) a year for each ship a year for each ship a year for each ship a year for each ship a year for each ship a year for each there were three de 0 PM; 3:00 PM -11:00 PM and 1:00 PM	with the mal signated of PM riday. The two do 9:00 ds on evealed by the		ensure compilance.		
. 3	Each GHMRP shall padministrative supponeeds of the resident Habilitation plans. This Statute is not maked on observation eview, the group for the following Administration of the property of	provide adequate rt to efficiently meet is as required by the set as evidenced by: n, interview, and recipersons with intelled	ord	I 180	(1,2,3) QIDP, House Manager (s) and all staf working with individuals #1 & 2 received re training on 6/24/11 on implementation for BS adherence to Meal Time Protocols and Porti Controls. Symbral's governing body, QA Team, QIDP, House Manager will continue to monitor to e compliance.	SP,	6/24/11 and ongoing

#536 P.019/031

Health Regulation & Licensing Administration						rordi	MATEROVEO
	NT OF CEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		(X2) MUL A. BUILD B. WING		(X3) DATE COMP	SURVEY LETED
		HFD03-0005				06/	10/2011
NAME OF I	PROVIDER OR SUPPLIER				, STATE, ZIP CODE		
SYMBR	AL FOUNDATION			STREET, NI GTON, DC			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY SCIDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPRIDEFICIENCY)	JLO BE	(X5) COMPLETE DATE
l 180	Continued From pa	ge 4		1180			
	Intellectual Disability coordinated and mo	ensure that the Qualies Professional (QIE politored services, for it. (Clients #1 and #2)	(P) two of		Continued from page 4.		
	The finding includes	3 :					
:	to ensure 1:1 staff d	3. The facility's QIDI lemonstrated compet #1's behavior suppo	tency in				
	failed to ensure Clie active treatment in a	249. The facility's QI ont #1 received continuccordance with the m (IDT) recommenda	uous				
	ensure that Clients #	460. The QIDP failed #1 and #2 received w meals in accordance	ell				
1 422	3521.3 HABILITATIO	ON AND TRAINING		1422			
	Each GHMRP shall and assistance to rea the resident 's Indivi	sidents in accordance	e with		Behavioral Specialist re-trained QIDP, I Manager (s) and all staff working with in #1 on his BSP and 1:1 job duties. Symbrat's governing body, QA Team, Be	dividual	6/24/11 and ongoing
	This Statute is not mage and the Based on observation review, the group how intellectual disabilities resident's Behavior Simplemented consister residents. (Resident:	n, interview, and recome for persons with s staff failed to ensur Support Plan (BSP) wently, for one of two s	e a		Specialist, QIDP and House Manager will to provide oversight.	i continue	
-	The finding includes:					,	
	The GHPID failed to 1:1 staff remained in accordance with his l	close proximity in				:	

#536 P.020/031

Health Regulation & Licensing Administration										
	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED				
	HFD03-0005			D. WING			10/2011			
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, STATE, ZIP CODE						
					STREET, NE STON, DC 20002					
(X4) ID PREFIX TAG				ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION (CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETE				
1 422	On June 8, 2011, at 4:10 p.m., Resident #1 was				Continued from page 5.					
	observed to walk over my hand and sat do remained in the kitop.m. the 1:1 staff repreparing dinner whithe dining table with Resident #1 answer located in the living phone to his 1:1 staresident #1 receive when standing to ck During this time, the kitchen. On June 9, #1 was left alone in approximately one malked upstairs. Interview with the 1: approximately 4:42 #1 received 1:1 staff	rer to the dining table own while his 1:1 staff then preparing dinner mained in the kitcher lile Resident #1 remained the surveyor. At 4:2 red the cordless telegroom area and broughf in the kitchen. At 1:4 verbal prompts to 20 to the female state 1:1 staff remained in 2011, at 4:48 p.m., the living room for ninute while his 1:1 staff on June 8, 20 p.m., revealed that Ring 24 hours a day to	to shake fr. At 4:15 n gined at 27 p.m., phone ght the 5:35 p.m., back up off. n the Resident 11, at tesident							
	manage his malada (i.e. inappropriate to person's personal spropositioning anoth screaming, and make comply with staff regard physical aggress. Resident #1's 1:1 stanot remain in close pobserved on June 8, Review of Resident #2011, on June 10, 20 the 1:1 staff's interview maladaptive behavior Resident #1's BSP in remain within close phome, community, discontinuation and personal staff's interview maladaptive behavior Resident #1's BSP in remain within close phome, community, discontinuation and personal staff's interview maladaptive behavior Resident #1's BSP in remain within close phome, community, discontinuation and personal staff in the personal st	ptive behaviors and suching, invading and security per person, cursing, yeing threats, refusing quests, verbal aggression). Further intervially acknowledged the proximity at all times 2011. #1's BSP dated Febro11, at 9:43 a.m., coper of the aforementing at all times are review of the aforementing at all times are and while being and while being	safety. ether relling, to ssion, iew with at he did as uary 28, nfirmed oned f							

#536 P.021/031

Health Regulation & Licensing Administration											
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED					
		HFD03-0005		B. WING		06/1	10/2011				
NAME OF PROVIDER OR SUPPLIER STREET AD					DORESS, CITY, STATE, ZIP CODE						
SYMBRAL FOUNDATION 722 "L" S WASHING					STREET, NE GTON, DC 20002						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETE					
1 422	Continued From page 6			1422							
`. :	transported). The BSP also added that Resident #1's 1:1 staffing was in place for safety precautions relative to sexually propositioning others.				Continued from page 6.						
;	At the time of the survey, there was no evidence that Resident #1's 1:1 staff implemented his BSP as recommended.										
•											
:			j								
				;							
·			·	; ;		, t t l l					